

TRICARE® Prime

A managed care option for active duty service members and their families and other TRICARE-eligible beneficiaries in Prime Service Areas

TRICARE Prime is a managed care option that is available to active duty service members (ADSMs), their family members, and certain other TRICARE-eligible beneficiaries in specific areas of the 50 United States. In overseas locations, TRICARE Overseas Program (TOP) Prime is available only to ADSMs and their command-sponsored family members. When you enroll in TRICARE Prime, you generally receive most of your routine care from a primary care manager (PCM) that you select or are assigned. Your PCM may be (1) at a military hospital or clinic; (2) a civilian TRICARE network provider within a TRICARE Prime Service Area (PSA); or (3) a primary care physician in the US Family Health Plan, depending on your location and sponsor status. Where you live and military hospital and clinic capacity levels will determine whether you will have a military hospital and clinic or civilian PCM.

Sponsors should ensure that their family members are properly registered in the Defense Enrollment Eligibility Reporting System (DEERS) and that they have up-to-date uniformed services identification cards. Visit www.tricare.mil/deers for more information.

ELIGIBILITY

For ADSMs located in areas where TRICARE Prime is available, enrollment in TRICARE Prime is mandatory. Active duty family members (ADFMs) and retirees and their family members may also enroll in TRICARE Prime if they live in a PSA. A PSA is a geographic area where TRICARE Prime is offered. It is typically an area near a military hospital or clinic.

Within PSAs, TRICARE Prime is available to:

- ADFMs
- Transitional survivors
- Certain former spouses who have not remarried

- Retirees, retiree family members, and survivors
- National Guard and Reserve members who are called or ordered to active service for more than 30 consecutive days and their eligible family members
- Medal of Honor recipients and their family members

For more information about these beneficiary categories, visit www.tricare.mil/eligibility. Your DEERS information, including your residential address and, if applicable, a separate mailing address, must be accurate and current. Otherwise, you may not be eligible to enroll in TRICARE Prime. Only sponsors (or sponsor-appointed individuals with valid power of attorney) can add family members to DEERS. Family members age 18 and older may update their own contact information in DEERS.

Note: ADSMs and their families who do not live in PSAs may enroll in a TRICARE Prime Remote option. For more information, visit www.tricare.mil/tpr.

ENROLLING IN TRICARE PRIME®

Eligible beneficiaries must be registered in DEERS and submit a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) to their regional contractors. Beneficiaries may also enroll online by visiting the Beneficiary Web Enrollment (BWE) Web site at www.dmdc.osd.mil/appj/bwe. Enrollment is open year-round. Enrollment forms received by your regional contractor by the 20th of the month become effective at the beginning of the following month (e.g., an application received by December 20 becomes effective January 1). If the application is received after the 20th of the month, coverage will become effective on the first day of the second month following the receipt of the enrollment form (e.g., an application received on December 27 becomes effective February 1). Visit www.tricare.mil/forms to download *DD Form* 2876.

YOUR TRICARE REGIONAL CONTRACTOR

Regional contractors administer the TRICARE medical benefit in each TRICARE region (North, South, and West). Visit your regional contractor's Web site for information about how to change your PCM, how to enroll family members, covered services, referral and prior authorization requirements, and other helpful information. See the For Information and Assistance section of this fact sheet for regional contractor contact information.

TRICARE-AUTHORIZED PROVIDER TYPES

TRICARE defines a provider as a person, business, or institution that provides health care. For example, doctors, hospitals, or ambulance companies are providers. Providers must be authorized under TRICARE regulations and have their status certified by the regional contractors to provide services to TRICARE beneficiaries.

TRICARE Provider Types

TRICARE-Authorized Providers

- TRICARE-authorized providers meet TRICARE licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers may include doctors, hospitals, ancillary providers (e.g., laboratories, radiology centers), and pharmacies that meet TRICARE requirements. If you see a provider that is not TRICARE-authorized, you are responsible for the full cost of care. To find a list of TRICARE-authorized providers, visit www.tricare.mil/findaprovider.
- There are two types of TRICARE-authorized providers: **network** and **non-network**.

Network Providers Non-Network Providers · Regional contractors have established · Non-network providers do not have a signed agreement with your regional contractor and networks and you may be assigned a are considered "out of network." In most cases, you will not receive care from non-network providers unless authorized by your regional contractor. You may seek care from a primary care manager (PCM) who is part of the TRICARE network. non-network provider in an emergency or if you are using the point-of-service (POS) option (using the POS option results in higher out-of-pocket costs). • When specialty care is needed, your best option is for your PCM • There are two types of non-network providers: participating and nonparticipating. to coordinate the referral with your **Participating Nonparticipating** regional contractor. • Using a participating provider is your best • If you visit a nonparticipating provider, • TRICARE network providers: option if you are seeing a non-network you may have to pay the provider first • Have a signed agreement with provider.

- your regional contractor to provide care
- · Agree to file claims for you
- Participating providers: · May choose to participate on a claimby-claim basis
- Have agreed to accept payment directly from TRICARE and accept the TRICARE-allowable charge (less any applicable patient cost-shares paid by you) as payment in full for their services
- and later file a claim with TRICARE for reimbursement.
- Nonparticipating providers:
 - · Have not agreed to accept the TRICAREallowable charge or file your claims
 - Have the legal right to charge you up to 15 percent above the TRICAREallowable charge for services (you are responsible for paying this amount in addition to any applicable patient cost-shares)1

^{1.} Overseas, there may be no limit to the amount that nonparticipating non-network providers may bill, and you may be responsible for paying any amount that exceeds the TRICARE-allowable charge. Visit www.tricare.mil/overseas for more information.

GETTING CARE WITH TRICARE PRIME

Emergency Care

TRICARE defines an emergency as a serious medical condition that the average person would consider to be a threat to life, limb, sight, or safety.

If you have an emergency, call 911 or go to the nearest emergency room. You do not need to call your PCM or regional contractor before receiving emergency medical care (*including overseas care*). However, in all emergencies, your PCM must be notified within 24 hours or on the next business day following admission to coordinate ongoing care and to ensure you receive proper authorization.

Note: Most dental emergencies, such as going to the emergency room for a severe toothache, are not a covered medical benefit under TRICARE. ADSMs receive dental care from military dental clinics and, if necessary, from civilian providers through

the TRICARE Active Duty Dental Program. ADFMs and retirees and their family members may be eligible to enroll in either the TRICARE Dental Program or the TRICARE Retiree Dental Program, depending on their status.

GETTING CARE WHEN TRAVELING OVERSEAS

With TRICARE Prime, you may receive care while traveling overseas from either a military hospital or clinic or a host nation (*overseas*) provider. When traveling overseas, plan for possible health care needs in advance of the trip. If you need emergency care, go to the nearest emergency care facility or call the TOP Medical Assistance number for the overseas area where you are traveling. If you are admitted, you must call your PCM and the TOP Regional Call Center within 24 hours or on the next business day after admission or, at the very latest, before leaving the facility. Call the TOP Regional Call Center to coordinate authorization, continued care, and payment, if applicable. Contact your PCM and the TOP Regional Call

Definitions and Examples of Types of Care

Type of Care	Definition	Primary Care Manager Role	Examples
Emergency	TRICARE defines an emergency as a serious medical condition that the average person would consider to be a threat to life, limb, sight, or safety.	You do not need to call your primary care manager (PCM) before receiving emergency medical care. Your PCM must be notified within 24 hours or on the next business day following admission.	No pulse, severe bleeding, spinal cord or back injury, chest pain, broken bone, inability to breathe
Urgent	Urgent care services are medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately, but that require professional attention within 24 hours. Urgent care services require a referral if you do not see your PCM for care.	Call your PCM first for appropriate guidance.	Minor cuts, migraine headache, urinary tract infection, sprain, earache, rising fever
Routine	Routine (<i>primary</i>) care is general health care and includes general office visits. Routine care also includes preventive care to help keep you healthy.	You will receive most of your routine care from your PCM.	Treatment of symptoms, chronic or acute illnesses and diseases, follow-up care for an ongoing medical condition
Specialty Care	Specialty care consists of specialized medical services provided by a physician specialist. Specialty care providers offer treatment that your PCM cannot provide.	Your PCM will refer you to another health care provider for care he or she cannot provide and will coordinate the referral with your regional contractor when necessary.	Cardiology, dermatology, gastroenterology, obstetrics

Center for urgent care. To locate an overseas provider, contact the TOP Regional Call Center where you are located or visit www.tricare-overseas.com.

If you are an ADSM traveling overseas or between duty stations and you are hospitalized, contact your regional contractor or service point of contact. If possible, ADSMs* traveling overseas should contact the local TOP Regional Call Center before seeking care or before making a payment. ADSMs must receive all nonemergency care, including urgent care, at a military hospital or clinic if one is available. If a military hospital or clinic is not available, prior authorization from your regional contractor is required. For urgent care overseas, ADSMs should contact the TOP Regional Call Center.

When seeking care from a host nation provider, be prepared to pay up front for services and then file a claim with the TOP claims processor. To process your claims reimbursements quickly and efficiently, you must submit proof of payment with all overseas claims. For more information, visit www.tricare.mil/claims.

Note: In the Philippines, you must use TRICARE-certified providers and pharmacies. To find a certified provider, visit www.tricare-overseas.com/philippines.htm.

* Includes National Guard and Reserve members called or ordered to active service 30 days or less, who should follow normal procedures for emergency care and must provide a copy of their orders to the nearest TOP Regional Call Center to verify TRICARE eligibility.

REFERRALS AND PRIOR AUTHORIZATIONS

Referrals

Under TRICARE Prime, your PCM will provide referrals for you to receive services from specialty care providers and will coordinate the referral request with your regional contractor when necessary. Some services do not require referrals, including clinical preventive services and the first eight outpatient behavioral health care visits per fiscal year (FY) to a network provider authorized under TRICARE regulations to see patients independently for a medically diagnosed and covered condition. If you seek care, including clinical preventive services or behavioral health care, from a non-network TRICARE-authorized provider without a referral from your PCM or authorization from your regional contractor, you will be using the point-of-service (POS) option, resulting in higher out-of-pocket costs. See the *TRICARE Prime Costs* section of this fact sheet for more information or visit www.tricare.mil/costs.

Note: ADSMs always require referrals for any civilian care, including clinical preventive services, behavioral health care, and specialty care (except for emergency services; for information about how TRICARE defines a medical emergency, see "Emergency Care" in the Getting Care with TRICARE Prime section of this fact sheet).

Prior Authorization

ADSMs require prior authorization for all inpatient and outpatient specialty services. An additional fitness-for-duty review is required for maternity care, physical therapy, behavioral health care services, and family counseling.

For all other TRICARE Prime enrollees, the following services require prior authorization:

- Adjunctive dental services (i.e., dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition)
- Extended Care Health Option services (ADFMs only)
- Home health care services
- Home infusion therapy
- Hospice care
- Nonemergency inpatient admissions for substance use disorders or behavioral health care
- Outpatient behavioral health care beginning with the ninth visit per FY
- Transplants—all solid organ and stem cell

This list is **not** all-inclusive.

Each regional contractor has additional prior authorization requirements. Visit your regional contractor's Web site or call the toll-free number to learn about your region's requirements, as they may change periodically.

FILING CLAIMS

In most cases, you will not need to file claims for health care services. However, there may be times when you will need to pay for care up front and then file a claim for reimbursement. You will be reimbursed for TRICARE-covered services at the TRICARE-allowable charge, less any copayments, cost-shares, or deductibles. For example, non-network nonparticipating providers may require that you pay up front for some services.

In the United States and U.S. territories (*American Samoa*, *Guam*, *the Northern Mariana Islands*, *Puerto Rico*, *and the U.S. Virgin Islands*), claims must be filed within one year of either the date of service or the date of inpatient discharge. Overseas, claims must be filed within three years of either the date of service or the date of inpatient discharge. You must submit proof of payment with all overseas claims.

To file a claim, obtain and complete a *TRICARE DoD/CHAMPUS Medical Claim—Patient's Request for Medical Payment* form (DD Form 2642). You can download *DD Form 2642* from the TRICARE Web site at www.tricare.mil/forms or from your regional contractor's Web site.

When filing a claim, attach a readable copy of the provider's bill to the claim form, making sure it contains the following information:

- Patient's name
- Sponsor's Social Security number (SSN) or Department of Defense Benefits Number (DBN) (eligible former spouses should use their own SSN or DBN, not the sponsor's)
- Provider's name and address (if more than one provider's name is on the bill, circle the name of the provider who delivered the service for which reimbursement is requested)
- Date and place of each service
- Description of each service or supply furnished
- Charge for each service
- Diagnosis (if the diagnosis is not on the bill, complete block 8a on the form)

If you receive care while traveling in the United States, you must file your TRICARE claims in the region where you live, not the region where you received care. If you receive care while traveling overseas (*including U.S. territories*), you must file your TRICARE claims with the TOP claims processor. For overseas claims information and mailing addresses, visit www.tricare-overseas.com/contactus.

COORDINATING CLAIMS WITH OTHER HEALTH INSURANCE

If you have OHI, fill out the TRICARE Other Health Insurance Questionnaire, available at www.tricare.mil/forms, to keep your regional contractor informed about your OHI so they can coordinate your benefits and help ensure that your claims are not delayed or denied. Follow the OHI's rules for filing claims and file the claim with the OHI first. If there is an amount your OHI does not cover, you or your provider can file the claim with TRICARE for reimbursement. It is important to meet your OHI's requirements. If your OHI denies a claim for failure to follow its rules, such as obtaining care without authorization or using a non-network provider, TRICARE may also deny your claim.

TRICARE PRIME COSTS

Enrollment Fees

There are no enrollment fees for ADSMs and their family members. Retired service members and their eligible family members, surviving spouses after the first three years, eligible former spouses, and others pay TRICARE Prime enrollment fees, which are applied to the annual catastrophic cap.

These fees are subject to change each FY. Survivors of deceased active duty sponsors and medically retired uniformed service members and their dependents enrolled in TRICARE Prime are exempt from future enrollment fee increases. The fees for the survivors and medically retired members and their

dependents will remain frozen at the rate in effect when they were classified and enrolled, as long as the policy remains active. The FY 2014 enrollment fees are as follows:

• Individual: \$273.84 per year

• Family: \$547.68 per year

For more information, please visit www.tricare.mil/costs.

Network Copayments

ADSMs do not pay any out-of-pocket costs for care. ADFMs generally do not pay out-of-pocket for their care except when using the POS option. For more information, see "Point-of-Service Option" later in this section.

Retired service members, their families, and all others pay the following copayments for care from TRICARE network providers. These costs are for care from civilian providers or for care received with a PCM referral, when required. For additional cost details, visit www.tricare.mil/costs.

Costs for Retirees, Their Families, and All Others

Type of Care	Network Copayment	
Ambulance Services	\$20 per occurrence	
Ambulatory (same day) Surgery	\$25 per visit	
Behavioral Health	Outpatient: \$25 (individual visit); \$17 (group visit) Hospitalization: \$40 per day (no charge for separately billed professional charges)	
Clinical Preventive Services	\$0 per visit	
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	20% of the negotiated fee	
Emergency Room Visit	\$30 per visit	
Home Health Care	\$0	
Hospice Care	\$0	
Hospitalization	\$11 per day (\$25 minimum)	
Lab and X-ray Services	\$12 per visit (unless billed as a clinical preventive service)	
Newborn Care	\$11 per day (\$25 minimum)	
Outpatient Visit	\$12 per visit	
Skilled Nursing Care	\$11 per day (\$25 minimum)	

Point-of-Service Option

The POS option gives you the freedom, at an additional cost, to receive nonemergency health care services from any TRICARE-authorized provider without requesting a referral from your PCM. For cost details, visit www.tricare.mil/costs.

The POS option does **not** apply to the following:

- ADSMs
- Newborns or newly adopted children in the first 60 days (120 days overseas) after birth or adoption
- Emergency care
- Clinical preventive care received from a network provider

- · Beneficiaries with OHI
- The first eight outpatient behavioral health care visits per FY to a network provider authorized under TRICARE regulations to see patients independently for a medically diagnosed and covered condition

You are responsible for any additional charges from non-network providers (up to 15 percent above the allowable charge is permitted by law in the United States and U.S. territories). POS fees do not apply toward the annual catastrophic cap, which is \$1,000 per year for active duty families and \$3,000 per year for all other families covered by TRICARE.

FOR INFORMATION AND ASSISTANCE

You can sign up to receive TRICARE news and benefit updates via e-mail. Visit www.tricare.mil/subscriptions, enter your e-mail address, and follow the prompts.



N TRICARE North Region

Health Net Federal Services, LLC 1-877-TRICARE (1-877-874-2273) www.hnfs.com

Send claims to:

Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740

Check the status of your claim at www.myTRICARE.com or www.hnfs.com



TRICARE South Region

Humana Military, a division of **Humana Government Business** 1-800-444-5445 Humana-Military.com

Send claims to:

TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031

Check the status of your claim at www.myTRICARE.com or Humana-Military.com



W TRICARE West Region

UnitedHealthcare Military & Veterans 1-877-988-WEST (1-877-988-9378) www.uhcmilitarywest.com

Send claims to:

TRICARE West Region Claims Department P.O. Box 7064 Camden, SC 29020-7064

Check the status of your claim at www.uhcmilitarywest.com

An Important Note About TRICARE Program Information

At the time of publication, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. Military hospital and clinic guidelines and policies may be different than those outlined in this publication. For the most recent information, contact your TRICARE regional contractor or local military hospital or clinic. The TRICARE program meets the minimum essential coverage requirement under the Affordable Care Act.